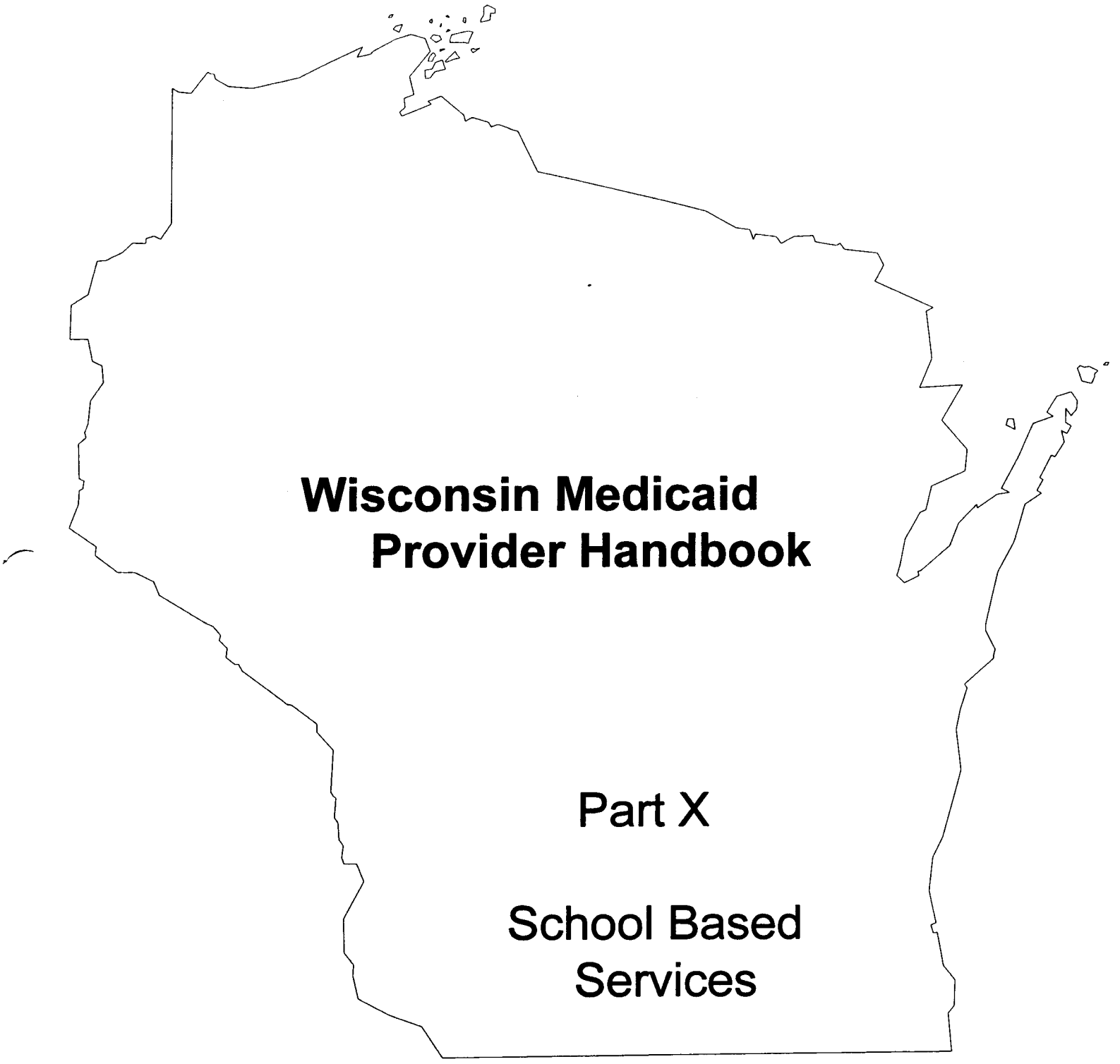

Wisconsin Medicaid Provider Handbook

Part X

School Based Services

Read all materials before initiating services to ensure a thorough understanding of Wisconsin Medicaid policy and billing procedures.

Introduction

Wisconsin Medicaid is governed by HSS 101-108, Wisconsin Administrative Code, and by state and federal law. Two parts of the Medicaid provider handbook interpret these regulations. The two parts of the handbook are designed for use with each other and with the Wisconsin Administrative Code.

Part A, the all-provider handbook, includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. The *service-specific* part of the handbook includes information on provider eligibility criteria, covered services, payment methodology, prior authorization, and billing instructions. Each provider is sent a copy of Part A, the all-provider handbook, and the appropriate service-specific handbook at the time of certification.

Purchase additional copies of provider handbooks by completing the order form in Appendix 36 in Part A, the all-provider handbook.

When requesting a handbook, be sure to indicate the service provided (i.e., physician, chiropractic, dental).

Note: For a complete source of Medicaid regulations and policies, refer to HSS 101-108, Wisconsin Administrative Code. In the event of any substantive conflict between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code holds. Providers may purchase HSS 101-108 from Document Sales at the address in Appendix 3 of Part A, the all-provider handbook.

There are other documents, including state and federal laws and regulations, relating to Wisconsin Medicaid:

- Sections 49.43 - 49.497, Wisconsin Statutes
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456

A list of common terms and their abbreviations is in Appendix 30 of Part A, the all-provider handbook, and in HSS 101, Wisconsin Administrative Code.

Part X
School Based Services
Transmittal Log

This log is designed as a convenient record sheet for recording receipt of handbook updates. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

Each update to Part X of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. For example, if the last transmittal number on your log is X-3 and you receive X-5, you are missing X-4. If a provider is missing a transmittal, copies of *complete* provider handbooks may be purchased by writing to the address in Appendix 36 of Part A, the all-provider handbook.

Transmittal Number	Initials	Issue Date

Transmittal Number	Initials	Issue Date

School Based Services
Table of Contents

A. Type of Handbook

Part X, School Based Services (SBS), is the service-specific portion of the Wisconsin Medicaid provider handbook. Part X includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, and billing instructions. Use Part X in conjunction with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all Medicaid-certified providers. As required under education laws, SBS providers must obtain permission to provide IEP/IFSP services.

B. Provider Information

Provider Eligibility and Certification

To participate as a Medicaid provider, a school district or Cooperative Educational Service Agency (CESA) must be certified as a provider under HSS 105.53, Wis. Admin. Code. Only a school district or CESA may be certified as an SBS provider. The school district or CESA must verify that individual staff meet qualifications under PI 3, Wis. Admin. Code, or are licensed under s.441.06, s.441.10, s.459.05 or s.459.24, Wis. Stats.

When applying for Medicaid SBS certification, school districts and CESAs must identify any other Medicaid provider certification they now hold (e.g., physical therapy, therapy group or HealthCheck).

Beginning July 1, 1996, legislation requires school districts and CESAs to bill SBS-covered services (listed in Section II) delivered at the school site under their SBS certification, instead of under a duplicate provider certification. SBS certification encompasses, and therefore duplicates all of the following Medicaid provider certifications (individual and group):

- audiologist;
- nurse practitioner, group and individual;
- nurse group and individual nurse;
- occupational therapy and therapy assistant;
- physical therapy and therapy assistant;
- rehabilitation agency;
- speech and hearing clinic;
- speech pathology/therapy;
- therapy group; and
- transportation.

Group certification for the duplicate service areas listed above held by a school district or CESA will be canceled effective July 1, 1996. In addition, school districts and CESAs are not eligible for new group certification for the above duplicate service areas beginning July 1, 1996.

Providers who are certified individually for one of the duplicate service areas listed above, and have a school district or CESA listed as their payee, must reassign their payee, or their Medicaid certification will be canceled after notice. After June 30, 1996, individuals cannot be certified for the above duplicate service areas when a school district or CESA is the provider's payee.

School districts and CESAs may be Medicaid-certified for any services, such as HealthCheck screening and prenatal care coordination (PNCC), as long as those services do *not* duplicate SBS services.

B. Provider Information (continued)

School districts may be Medicaid-certified under a CESA's umbrella certification, *or* be separately certified as a school district, but not both. CESAs applying for SBS certification, must identify the school districts included in their certification and must notify the Medicaid fiscal intermediary when these districts change.

Provider Authority to Subcontract

SBS providers may contract with agencies or individuals that are not certified under the SBS benefit to provide services at school sites. However, these services must be billed to Wisconsin Medicaid by the SBS provider.

The SBS provider is responsible for assuring all program requirements are met by subcontracted agencies or individuals.

Provider Responsibilities

Specific responsibilities as a certified provider are in Section IV of Part A, the all-provider handbook. Refer to Section IV of Part A, the all-provider handbook for information about:

- additional state and federal requirements;
- fair treatment of the recipient;
- maintenance of records;
- recipient requests for noncovered services;
- services rendered to a recipient during periods of retroactive eligibility; and
- grounds for provider sanctions.

C. Reimbursement

Statewide contract rates are set by the Department of Health and Social Services (DHSS), for all SBS covered services. On a yearly basis, providers who complete the appropriate forms will be paid according to a district-specific cost-based rate schedule.

SBS providers are required to annually certify sufficient non-federal funds to match the federal share of all Medicaid payments (local "match" money). Funding used for match must be spent on services eligible for Medicaid coverage, and provided to Medicaid-eligible children. See Appendices 9 and 10 for a sample of the form required to certify local match, and an optional worksheet to support this certification.

Provider documentation verifying the amount of matching funds that have been certified must be maintained for at least five years.

D. Recipient Information

Consent

To the extent required by federal and state education regulations, schools must have informed, written consent from a parent, guardian or adult pupil before disclosing personally identifiable information in student records to either obtain Medicaid eligibility information or to bill Wisconsin Medicaid. As required under education laws, SBS providers must obtain parental permission to provide IEP/IFSP services.

For further information, refer to the school district's confidentiality policies, or contact the Wisconsin Department of Public Instruction (DPI).

Appendix 8 contains a sample consent form for obtaining informed consent to verify Medicaid eligibility and to bill Wisconsin Medicaid.

Note: Consent must also be obtained to bill health insurance.

D. Recipient Information (continued)

Verifying Recipient Eligibility

Each month, Medicaid recipients receive identification cards that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code and, when applicable, an indicator of health insurance, enrollment in a Medicaid HMO, and Medicare coverage.

Section V of Part A, the all-provider handbook, provides detailed information regarding eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and eligibility verification. *Review* Section V of Part A, the all-provider handbook, *before* billing for services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

Volume Eligibility

If a provider cannot obtain a copy of an identification card, the provider may want to use the Medicaid Volume Eligibility System. The Medicaid Volume Eligibility system allows providers to make a large number of Wisconsin Medicaid recipient eligibility inquiries, and receive a reply to their inquiries. Providers need to contact EDS at (608) 221-4746 and ask for the Electronic Media Claims (EMC) department for further information.

Recipients Enrolled In Medicaid HMOs

SBS providers can bill Wisconsin Medicaid directly for services provided to recipients enrolled in a Medicaid HMO. These recipients receive a yellow identification card. This card has a six-character code in the "Other Coverage" column identifying the recipient's HMO. The codes are defined in Appendices 20, 21, 22, 22a, and 22b of Part A, the all-provider handbook.

For information regarding provider responsibilities when recipients are enrolled in Medicaid HMOs, refer to Section II-D of this handbook.

Medicaid Recipients Eligible for Tuberculosis-Related Services Only

Wisconsin Medicaid covers a limited range of services directly related to the treatment of tuberculosis (TB). These recipients, also known as TR recipients, are identified by the following Medicaid eligibility code medical status code, which is on the identification card:

TR Tuberculosis-related services

This information may also be obtained from the fiscal agent's eligibility information sources, including Volume Eligibility.

SBS providers may only provide TB-related nursing services to TR recipients. When doing so, the following conditions must be met:

- the service is included in the school district's or CESA's Individualized Education Program (IEP) or Individualized Family Service Program (IFSP) for the child;
- the service is medically necessary; and
- the service meets the record keeping and other requirements for SBS.

D. Recipient Information (continued)

Delivery of these services must be performed by school nursing staff or as a delegated nursing act, and must be coordinated with the individual's physician and/or the county public health department.

Section V of Part A, the all-provider handbook, defines other special benefit categories with restricted Medicaid coverage.

Copayment

Copayments are not required for SBS services.

A. Introduction to Covered Services

Wisconsin Act 27, Laws of 1995, the biennial budget, established the School Based Services (SBS) benefit. The benefit allows school districts and CESAs to bill Wisconsin Medicaid for medically necessary services provided to Medicaid-eligible children under age 21, or for any school term during which the individual became 21 years old. This benefit is effective for dates of service on and after July 1, 1995. As required under education laws, SBS providers must obtain parental permission to provide IEP/IFSP services.

All Medicaid-covered services must be medically necessary [HSS 101 (96m), Wis. Admin. Code.] An SBS service is medically necessary when the service meets all of the following conditions:

- identifies, treats, manages, or addresses a medical problem, or a mental, emotional or physical disability;
- is identified in a school district's or CESAs Individualized Education Program (IEP) or Individualized Family Service Program (IFSP) for the child;
- is necessary for a child to benefit from special education; and
- is referred or prescribed by a physician. Certain services may also be referred or prescribed by a nurse practitioner with prescribing authority, or a licensed Ph.D. psychologist. All referrals or prescriptions must be updated at least annually.

B. Covered Services

This section provides detailed information on the services covered under the SBS benefit. The services must be identified in the child's IEP or IFSP and certain limitations and requirements must be met. These services are:

1. speech-language, audiology and hearing;
2. physical therapy;
3. occupational therapy;
4. nursing;
5. psychological services, counseling and social work;
6. developmental testing and assessments when they result in an IEP/IFSP;
7. transportation; and
8. durable medical equipment.

Report and bill only face-to-face time for all SBS services. While consultation, monitoring and coordination are not separately payable by Wisconsin Medicaid, payment for these services is included in the reimbursement rate for the face-to-face services listed below.

Treatment Goals and Care Plan

For Wisconsin Medicaid coverage of SBS services, there must be a care plan which identifies treatment goals that are measurable and outcome-oriented. When the treatment goals identified in the IEP/IFSP are measurable and outcome oriented, the IEP/IFSP is considered the care plan. Otherwise, providers must develop a separate care plan that contains measurable and outcome-oriented goals.

B. Covered Services (continued)

Speech-Language, Audiology and Hearing Services

Speech-language, audiology and hearing services are covered for children with speech/language or hearing disorders that adversely affect the child's functioning. The following services are covered:

- evaluation and testing to determine the child's need for these services and recommendations for a course of treatment;
- individual therapy; and
- group therapy in groups of 2 to 7 children.

These services must have a physician's referral and be identified in an IEP or IFSP. Services must be performed by or under the direction of a licensed Department of Public Instruction (DPI)-certified speech pathologist or audiologist.

Physical Therapy Services

Covered SBS IEP/IFSP physical therapy services identify, treat, rehabilitate, restore, improve or compensate for medical problems. The following services are covered:

- evaluation and testing to determine the child's need for these services and recommendations for a course of treatment;
- individual therapy; and
- group therapy in groups of 2 to 7 children.

These services must be prescribed by a physician and identified in an IEP or IFSP. Services must be performed by or under the direction of a DPI-certified physical therapist.

Occupational Therapy Services

Occupational therapy services are covered when they identify, treat, rehabilitate, restore, improve or compensate for medical problems that interfere with age appropriate functional performance. The following services are covered:

- evaluation and testing to determine the child's need for these services and recommendations for a course of treatment;
- individual therapy; and
- group therapy in groups of 2 to 7 children.

These services must be prescribed by a physician and be identified in the IEP/IFSP. Services must be provided by or under direction of a DPI-certified occupational therapist.

B. Covered Services (continued)

Nursing Services

Nursing services must be relevant to the child's medical needs. Services include, but are not limited to:

- evaluation and management services, including screens and referrals for health needs;
- treatment and other measures; and
- medication management.

These services must be prescribed or referred by a physician or advance practice nurse with prescribing authority, and must be identified in an IEP or IFSP. Services must be performed by a registered nurse, licensed practical nurse or are delegated under nursing protocols.

Psychological Services, Counseling and Social Work Services

Psychological services, counseling and social work services include diagnostic or active treatments intended to reasonably improve the child's physical or mental condition. The following services are covered:

- diagnostic testing and evaluation that appraise cognitive, emotional, and social functioning and self concept;
- therapy and treatment that plans, manages and provides a program of psychological services, counseling or social work services to children with psychological or behavioral problems;
- crisis intervention;
- individual treatment, counseling and social work services; and
- group treatment, counseling and social work services in groups of 2 to 10.

These services must be prescribed or referred by a physician or licensed Ph.D. psychologist and identified in the IEP or IFSP. Services must be provided by a DPI-certified school psychologist, school counselor or social worker.

Other Developmental Testing and Assessments

Other developmental testing and assessments include activities that must be performed to determine if motor, speech-language, cognitive or psychological problems exist, or to detect developmental lags, provided the activities result in an IEP/IFSP. The following face-to-face services are covered:

- evaluations;
- tests; and
- related activities.

These services may be performed by special education teachers, diagnostic teachers and other qualified teachers. Wisconsin Medicaid also covers these services when performed by therapists, psychologists, social workers, counselors and nurses as part of their respective areas, provided these activities result in an IEP/IFSP.

B. Covered Services (continued)

Transportation Services Requiring a Ramp or Lift

Covered transportation services are provided to children who require transportation in vehicles equipped with a ramp or lift. The need for special transportation must be identified in the child's IEP/IFSP. Both loaded (with children in the vehicle) and unloaded mileage (without children in the vehicle) may be billed to Wisconsin Medicaid. Transportation services include:

- transportation from the child's home to and from school on the same day another SBS covered service is provided in the school; or
- transportation from school to a service site and back to school or home if the other SBS covered service is provided at a non-school location, such as a hospital.

A prescription from a physician or advance practice nurse with prescribing authority is required to show the child's need for special transportation. Only transportation to a Medicaid covered service is covered.

Note: Requests for common carrier transportation (i.e., transportation in vehicles without ramps or lifts) must go to the county department of human/social services, or appropriate tribal agency. Wisconsin Medicaid reimburses county and tribal agencies for medically necessary common carrier transportation authorized by the county or tribe. Refer to HSS 107.23 (d), Wis. Admin. Code, for further information.

Durable Medical Equipment (DME)

DME is covered under the SBS benefit when:

- the need for the equipment is identified in the IEP or IFSP;
- the equipment is used by only one child; and
- the child uses the equipment at school and home (the child owns the equipment, not the school, school district or CESA).

Wisconsin Medicaid covers medically necessary equipment under the SBS benefit only when the child requires IEP/IFSP medically necessary equipment that is *not* covered under Wisconsin Medicaid's DME benefit. Contact the fiscal agent (EDS) or a Medicaid-certified DME supplier to determine if a particular item is covered by Medicaid.

C. Noncovered Services

The following services are not covered under the SBS benefit:

1. art, music and recreational therapies;
2. services that are strictly educational, vocational or pre-vocational in nature, or without a defined medical component, e.g., vocabulary development, specialized [adaptive] physical education classes, rote learning skills (counting, name printing, coin labeling);
3. services performed by providers who are not certified for SBS services;

C. Noncovered Services (continued)

4. services, including school health program services, that are not in the child's IEP/IFSP;
5. general classroom instruction and programming, e.g., developmental guidance in the classroom;
6. staff development and in-services to school staff and parents;
7. general research and evaluation of the effectiveness of school programs;
8. program coordination of gifted and talented or student assistance programs;
9. kindergarten or other routine screening provided free of charge unless resulting in an IEP or IFSP referral. (Note: HealthCheck screens are billable to Wisconsin Medicaid by Medicaid HealthCheck providers, but are not billable under SBS);
10. diapering; and
11. non-medical feeding, i.e., that is not tube feeding or part of a medical program such as a behavior management program.

D. Communication With Other Medicaid Providers

When a child receives similar Medicaid services from SBS and non-SBS providers, these providers *must* communicate with each other to:

- ensure service coordination;
- avoid duplication of services; and
- facilitate continuity of care.

To ensure communication, Wisconsin Medicaid requires SBS providers to:

1. Sign joint Memorandums of Understanding (MOUs) with Medicaid-contracted HMOs serving their areas. MOUs are documents that set standards, policies and procedures to help coordinate care and avoid duplication of services.

   Wisconsin Medicaid will facilitate the development of MOUs between SBS providers and Medicaid HMOs as follows:

   - Wisconsin Medicaid will provide SBS providers with a complete listing of Medicaid HMOs.
   - Wisconsin Medicaid will notify Medicaid-contracted HMOs when school districts and CESAs in their areas have obtained Medicaid certification as SBS providers.

D. Communication With Other Medicaid Providers (continued)

2. When a child receives services from both an SBS provider and a fee-for-service non-HMO provider, the SBS provider must:

   - document regular contacts with fee-for-service providers at least annually, as appropriate for each child; and
   - cooperate with Medicaid fee-for-service providers who request copies of the child's IEP/ IFSP or components of the multi-disciplinary team (M-Team) evaluation.

Fee-for-service providers include: Medicaid clinics, rehabilitation agencies, local health departments, community mental health agencies, tribal health agencies, home care agencies and therapists.

E. Record Keeping

Certified SBS providers are required to keep the following minimum information to bill Wisconsin Medicaid. In addition, this information must be kept in the child's record for at least five years:

- the child's first name and last name, and date of birth;
- the prescription or referral for the service which must be updated at least annually;
- all documentation used to develop an IEP or IFSP (M-Team reports, test, etc.);
- the annual IEP or IFSP revision documenting the child's progress toward the treatment goals, changes in physical or mental status, and changes in the treatment plan (not required for transportation);
- the date(s) of service;
- the general service category(s) provided (e.g., nursing);
- a brief description of the specific service provided [e.g., activities of daily living (ADL) buttoning skills, range of motion (ROM) elbow, wrist, medication management];
- the unit of service delivered, including as appropriate:
  - service time for face-to-face professional services;
  - quantity of equipment;
  - miles for transportation.

  (Refer to Appendix 6 of this handbook for unit guidelines.)

- a description of durable medical equipment (DME) that allows Wisconsin Medicaid to determine the reimbursement rate. (Include the item name and model number or a description, and the invoice, receipt or cost.)

E. Record Keeping (continued)

- whether the service was provided in a group or individual setting;
- a brief description of the child's response to the service and progress, e.g., increased left knee extension to minus 5, (not required for transportation); and
- the signature of the individual who provided the face-to-face service.

For standard record keeping requirements, refer to Section IV in Part A, the all-provider handbook. For a sample activity log, refer to Appendix 7 of this handbook. Wisconsin Medicaid does not require a particular format for data collection.

A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. (Exceptions to this policy are certain governmental programs listed in Section IX of Part A, the all-provider handbook.)

If a child is covered under health insurance, Wisconsin Medicaid normally pays the remaining portion of the allowable cost remaining after exhausting all health insurance sources.

SBS providers should use the following guidelines when a Medicaid-eligible child has health insurance coverage:

- Because the following services are generally not covered by health insurance, they may be billed directly to Wisconsin regardless of health insurance coverage:

  1. counseling provided by a guidance counselor or social worker;
  2. developmental testing;
  3. school nursing;
  4. social work; and
  5. non-emergency transportation.

- If the child's health insurance contains a policy clause stating that services provided in a school setting are not covered, *all* SBS services may be billed directly to Wisconsin Medicaid.

- If the child's health insurance does cover services provided in a school setting, the SBS provider must either:

  1. Assume the costs for services that would be the responsibility of the health insurance carrier; or
  2. Bill covered services to the insurance carrier before billing Wisconsin Medicaid.

Those services that the SBS provider must either assume the cost of, or bill to the child's insurance carrier are:

- DME;
- Group or individual psychological counseling provided by a psychologist or psychiatrist; and
- The first 40 visits of group or individual occupational, physical, or speech-language therapy. Each calendar year, Wisconsin Medicaid can be billed beginning with visit 41.

When billing insurance, refer to Appendix 2 of this handbook for other insurance codes to be indicated on the HCFA 1500 claim form.

B. Billing Requirements and Limitations

Face-to-Face Time

Report and bill only face-to-face encounter time for all SBS services. Face-to-face time is the time the provider spends face-to-face with the child present in the course of providing the service. This includes:

- time to obtain and update a history with the child present;

- direct observation of the child;

B. Billing Requirements and Limitations (continued)

- M-Team testing and assessment with the child present; and
- delivery of the IEP therapy, psychological services, counseling, social work or nursing services.

Nonface-to-Face Time

While nonface-to-face time is not separately billable to Wisconsin Medicaid, payment is included in the reimbursement rate for the face-to-face services. Most medical providers, such as physicians, charge their patients only for face-to-face time, but include indirect costs in their charges. Nonface-to-face time is the time that providers spend in preparation and follow-up without the child present, including:

- reviewing and scoring records and tests;
- writing reports;
- monitoring and coordination of services;
- arranging for further services; and
- communication and consultation related to the M-Team or IEP service with other professionals, staff and parents.

C. Claim Submission

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as paper claims. Providers submitting electronically usually reduce their claim submission errors.

Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Submit procedure codes for School Based Services on the HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Procedure codes for School Based Services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the fiscal agent. HCFA 1500 claim forms are available from many suppliers including:

State Medical Society Services
P.O. Box 1109
Madison, WI 53701
(608) 257-6781
(800) 362-9080

C. Claim Submission (continued)

Mail completed claims submitted for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

The fiscal agent must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and the requirements for submission to Late Billing Appeals are in Section IX of Part A, the all-provider handbook.

D. Follow-Up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending or denied. Providers are advised that the fiscal agent takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.